

**RULES  
OF  
THE TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE  
DIVISION OF INSURANCE**

**CHAPTER 0780-1-20  
FILING AND APPROVAL OF ACCIDENT AND SICKNESS POLICIES, EXCEPT  
CREDIT ACCIDENT AND SICKNESS POLICIES, PREMIUM RATES, AND CLAIM FORMS**

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**0780-1-20-.01 GENERAL FILING REQUIREMENTS**

- (1) All the provisions of this Rule 0780-1-20-.01 through 0780-1-20-.08 apply to individual policy forms except as specifically provided in 0780-1-20-.01 (9) and 0780-1-20-.06 (4).
- (2) Each form shall be listed in a covering letter or in an attached list and all covering letters and lists shall be in duplicate. Rates and subsequent rate revisions must be filed with all accident and sickness policy forms as specified in *T.C.A. §56-26-102*, and each policy form filing must be accompanied by a schedule of the proposed premium rates, except revised policy forms previously filed, rider and endorsement forms which do not require a change in rates.
- (3) The marketing method to be used (e.g., individual sales, franchise, blanket, direct mail, group) shall be identified. Submission of mass-marketed policies, excluding individually marketed and underwritten policies and group policies as defined in *T.C.A. §56-26-201*, shall include a description of the marketing program and state any fees involved.
- (4) All filings must be submitted by the company concerned. If the filing is submitted through a third party, the filing should be accompanied by a letter of authorization signed by an officer of the insurance company.
- (5) Required forms and provisions and permissible policy provisions are contained in Chapter 7 and 26 and Section 56-3-201 of the Tennessee Insurance Laws, and amendments thereto made effective after the date of this Rule. Chapter 8 and certain Rules also affect the approval of accident and sickness policies.
- (6) If the form being submitted is intended to replace a form already on file, a list of the material changes made in the new form must accompany the transmittal letter.
- (7) All blank spaces in each policy form, except an application, must be filed in and completed with hypothetical data to indicate the purpose and use of the form.
- (8) When submitting a policy form to which a copy of the application must be attached when issued, a copy of the appropriate application shall be attached to the policy form. If the application has already been approved, the form number and date of approval shall be stated in the transmittal letter.
- (9) The requirements of this paragraph shall apply solely to group accident and sickness policies and forms.

(Rule 0780-1-20-.01, continued)

- (a) As to experience-rated group insurance, premium rates and classifications need not be filed, however, form filings must be accompanied by a statement signed by an authorized person on behalf of the company that (i) the policy filing is experience-rated group insurance, and (ii) the premium rates and classification of risks are available for review by the Commissioner of Insurance upon request.
- (b) As to other than experience-rated group insurance, the applicable premium rates and classifications must accompany the form filing, and the filing must be accompanied by a certification by an authorized person on behalf of the company that the premium rates are not unreasonable in relation to benefits provided, and that actuarial data and experience shall be maintained by the company and available for review by the Commissioner of Insurance upon request.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.02 ACTUARIAL MEMORANDUM.** Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called “anticipated loss ratio,” of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary’s knowledge and judgement the rate filing is in compliance with the applicable laws and regulations of this state and that the benefits are reasonable in relation to premiums.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.03 PREVIOUSLY APPROVED FORMS.** Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

- (1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form.
- (2) A statement as to whether the filing applies only to new business, only to in-force business, or both, and the reasons therefor.
- (3) A history of the experience under existing rates, including at least the data indicated in section 0780-1-20-.04. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.
- (4) The date and magnitude of each previous rate change, if any.

(Rule 0780-1-20-.03, continued)

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.04 EXPERIENCE RECORDS.** Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.05 EVALUATING EXPERIENCE DATA.** In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

- (1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.
- (2) Experienced and projected trends relative to the kind of coverage, e.g. inflation in medical expenses, economic cycles affecting disability income experience.
- (3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.
- (4) The mix of business by risk classification.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.06 REASONABLENESS OF BENEFITS IN RELATION TO PREMIUMS.**

- (1) New Forms

With respect to a new form, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

If satisfactory justification is submitted to the Department of Insurance for a policy form, including riders and endorsements, under which the expected average annual premium per policy is \$100 or more

(Rule 0780-1-20-.06, continued)

but less than \$200, the company may be permitted to subtract up to 5 percentage points from the numbers in the table above, or if less than \$100, subtract up to 10 percentage points.

The average annual premium per policy and the average anticipated loss ratio shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

#### Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Non-Cancellable: renewal cannot be declined nor can rates be revised by the insurance company.

(2) *Rate Revisions.* With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided the following standards are met.

(a) With respect to policies issued on and after the effective date of the revision, the standards are the same as in 0780-1-20-.06 (1) or .06 (4), except that the average annual premiums shall be determined based on an actual rather than an anticipated distribution of business.

(b) With respect to policies issued prior to the effective date of the revision, both (a) and (b) as follows shall be at least as great as the standards in 0780-1-20-.06 (1) or .06 (4).

1. The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

2. The ratio of (i) to (ii); where

(i) is the sum of the accumulated benefits, from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and

(ii) is the sum of the accumulated premiums, from the original effective date of the form to the effective date of the revision, and the present value of the future premiums,

such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

(Rule 0780-1-20-.06, continued)

3. Other methods, in addition to those in this subsection, 0780-1-20-.06 (2) may be used to calculate rate revisions. However, the minimum anticipated loss ratio thus calculated must be at least as great as the standards in 0780-1-20-.06 (1) or .06 (4), with consideration given active life reserves, and such methods must be approved by the Insurance Commissioner.
- (3) Anticipated loss ratios different from those indicated in (1) and (2) will require justification based on the special circumstances that may be applicable.
- (a) Examples of coverages that may receive special consideration are as follows:
1. accident only;
  2. short term non-renewable, e.g., airline trip; student accident;
  3. specified peril, e.g., cancer, common carrier;
  4. other special risks.
- (b) Examples of other factors that may receive special consideration are as follows:
1. marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
  2. extraordinary expenses;
  3. high risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;
  4. product features such as long elimination periods, high deductibles and high maximum limits.
- Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

(4) Medicare Supplement Policies

Benefits provided under Medicare Supplement policy forms which are designed primarily to supplement hospital, medical or surgical expenses incurred by the insured which are not covered by Medicare, shall be deemed reasonable in relation to premiums charged provided:

- (a) as to individual forms, the anticipated loss ratio is at least 60%, and
- (b) as to group forms, the anticipated loss ratio is at least 75%.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.07 ACCIDENT AND HEALTH POLICY EXPERIENCE EXHIBIT.** If the loss ratio shown in this Exhibit for a particular policy form, based on a substantial volume of reasonably mature business, is substantially lower than the applicable ratio set out in Rule 0780-1-20-.06, the company will be required to demonstrate under the standards in rule 0780-1-20-.06 why the rates charged should not be regarded as unreasonably high in relation to the benefits provided. If such demonstration cannot be made, the company will be required to cease selling that policy form in Tennessee, or it will reduce the premiums or increase benefits so as to comply with these rules.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.08 EFFECTIVE DATE.** The effective date of this Rule shall be January 1, 1981.

**Authority:** T.C.A. §§56-1-701, 56-26-114, 56-26-102, and 56-26-103. **Administrative History:** Original rule certified June 10, 1974. Amendment filed October 23, 1975; effective November 24, 1975. Repeal and new rule filed October 27, 1980; effective December 11, 1980.

**0780-1-20-.09 CLAIM FORMS FOR REPORTING BY HEALTH CARE PROVIDERS**

- (1) No later than July 1, 1994, all insurance companies offering for sale health care policies in this state shall require all policyholders and third party claimants to utilize the following standardized forms when making a claim against any health care insurance policy in effect in this state:
  - (a) Health Care Financing Administration (HCFA) Form 1500 for health care practitioner claims other than dental. Health care practitioners who bill patients directly shall provide a properly completed HCFA Form 1500 in addition to any other form used to bill the patient when requested by the patient.
  - (b) Form UB92 for hospital and other institutional care claims. Institutional care practitioners who bill patients directly shall provide a properly completed UB92 in addition to any other form used to bill the patient when requested by the patient.
  - (c) American Dental Association Form J512 for dental health care claims. Dentists who bill patients directly shall provide a properly completed J512 in addition to any other form used to bill the patient when requested by the patient.
  - (d) The National Council for Prescription Drug Programs (NCPDP) Universal Claim Form for pharmacy claims. Pharmacists who bill patients directly shall provide a properly completed Universal Claim Form in addition to any other form used to bill the patient when requested by the patient.
  - (e) The ANSI X12N standard format for the health care transaction sets for claims submission (837) and claims payment (835) for all issuers and health care providers who receive claims or sent payment by electronic means.
- (2) All forms required by this section shall be updated to meet the requirements of federal law or state laws implementing federal or state health care reimbursement programs

**Authority:** T.C.A. §56-7-1008. **Administrative History:** Original rule filed February 8, 1984; effective March 1984. Amendment filed June 3, 1994; effective August 15, 1994.